DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

19 OCT 2004

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SGO
110 Luke Avenue, Room 400
Bolling AFB DC 20032-7050

SUBJECT: Air Force Policy On Open Access (OA) Appointing For Primary Care

Open access appointing has been implemented at many of our MTFs, but its execution has been inconsistent and the effectiveness of its performance cannot be adequately measured. The Air Force Medical Service (AFMS) Access To Care Program has verified through site visits and metrics that there is wide variation in OA appointing practices across the AFMS. To reduce variation, improve patient access, increase potential for success and to provide clear implementation guidance to AFMS MTFs wanting to engage in OA appointing, the AFMS Medical Operations Panel chartered the OA Working Integrated Project Team (WIPT) to develop standard OA appointing business rules, policies and implementation procedures. This group includes representatives from all of our MAJCOMs as well as MTF appointing subject matter experts.

I fully endorse the policy guidance that the OA WIPT developed and direct that it be implemented AFMS wide effective 1 January 2005. Your full support of this policy will ensure consistent application of business processes and allow for the development of meaningful OA performance measures and metrics for those MTFs that decide to adopt this appointment strategy. To assist MTFs that are either considering changing their present traditional methods of appointing to the AFMS OA appointing, or bringing their own version of OA appointing into compliance with this policy, the AFMS OA WIPT has developed the *AFMS OA Implementation and Sustainment Plan* which establishes processes that these sites must take prior to implementation of AFMS OA appointing.

My POC is Maj Mark Meersman, AFMS Access Program Manager, who can be reached at (703) 681-6193, DSN 761-6193 or email at mark.meersman@pentagon.af.mil.

JOSEPH E. KELLEY
Major General, USAF, MC, CFS
Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

Attachments:
Air Force Medical Service Policy On Open Access Appointing For Primary Care, dated 1 Oct 04
Air Force Medical Service Open Access Implementation and Sustainment Plan

AIR FORCE MEDICAL SERVICE POLICY ON
OPEN ACCESS APPOINTING FOR PRIMARY CARE
1 October 2004
Effective Date: 1 January 2005

1. Purpose.

1.1. This policy guidance establishes roles, responsibilities and a standard method of implementing, sustaining and measuring Open Access (OA) appointing for Air Force Medical Service (AFMS) Primary Care Elements (PCE)/Clinics.

1.2. The AFMS defines OA appointing as follows: OA appointing is a process of developing schedules and booking medical appointments, designed to offer each patient requesting Primary Care services a same day appointment. The principle "Do today's work by close of business today" is the foundation of the AFMS OA appointing methodology. However, if the patient does not desire a same day appointment, appointments on ensuing days (Good Backlog Appointments) will be available and offered. Air Force Medical Service Medical Treatment Facilities (MTFs) using the OA appointing methodology will give patients an appointment or resolve their health care needs during their initial request or telephone call. This methodology will be followed throughout the AFMS so that consistent services will be offered from MTF to MTF.

1.3 Operational requirements for PCEs and or clinics implementing or already engaged in OA appointing. To ensure that PCEs and or clinics implementing or already engaged in OA appointing are successful, the following recommended minimum requirements should be followed:

1.3.1. Assignment of all team members to an OA PCE, to include providers, nurses, and support staff should be no less than an 18-month continuous period.

1.3.2. Not less than 75 percent of support staff should be available to OA PCE's during OA patient care hours.

1.3.3. A PCE and or clinic implementing or already engaged in OA appointing should not have more than:

1.3.3.1. 4500 enrollees for a PCE with 3 Primary Care Managers (PCMs) assigned.

1.3.3.2. 6000 enrollees for a PCE with 4 PCMs assigned.

1.3.3.3. 7500 enrollees for a PCE with 5 PCMs assigned.

1.3.3.4. 9000 enrollees for a PCE with 6 PCMs assigned.

1.3.4. PCEs and/or clinics implementing or already engaged in OA appointing will have ample supply of appointments available to accommodate their patient's needs. PCE Leaders will work closely with their Group Practice Managers (GPM), Health Care Integrators (HCI), and population health staffs to determine the best mix of appointment types and appropriate numbers given the day of the week and the time of year.

2. References. The following references should be used. All are viewable on the AFMS Knowledge Exchange at URL: https://kx.afms.mil/healthbenefits

2.1. AFMS Open Access Implementation and Sustainment Plan (attachment 1) dated 1 October 2004.

2.2. Commander's Guide For Access Success dated 15 August 2003.

2.3. TRICARE Europe Open Access Implementation Manual dated 2 May 03

2.4. Open Access Review and Recommendations, Final Report dated August 2002.

2.5. AFMS Policy on The Primary Care Element dated 11 March 2004 with additions made to this policy on 3 May 2004 and 17 June 2004.

3. Scope.

3.1. This policy is applicable to all AFMS MTF PCEs and/or primary care clinics.

3.2. MTFs contemplating implementation of OA appointing must consider numerous processes that will impact this method's success. These processes include the MTF telephone system; variations in patient demand; provider staff stability to include summer Permanent Change of Station (PCS) rotation schedules; Operations Tempo; Primary Care Optimization (PCO) level; graduate medical education programs; patient acuity; MTF inpatient versus ambulatory responsibilities; dedicated data analysis support; Group Practice Manager/Health Care Integrator capabilities and knowledge; experience of appointing staff; medical records availability; provider/staff commitment or "buy-in"; and the presence of a physician champion.

3.3. This policy is applicable to OA PCEs and or clinics contemplating or already engaged in OA appointing with the corresponding Medical Expense and Personnel Reporting System (MEPRS) codes defined as:

3.3.1. Family Practice - BGA

3.3.2. Primary Care - BHA

3.3.3. Pediatrics - BDA/BDB/BDC

3.3.4. Flight Medicine - BJA

3.3.5. General Internal Medicine - BAA

3.4. The smallest level organization in the MTF that can implement OA appointing is the PCE. Individual or pairs of PCMs are not allowed to enter into OA appointing. Small facilities that do not have enough providers to constitute a PCE may engage in OA appointing by using these guidelines.

3.5. PCEs will be established in accordance with AFMS PCE Policy Guidance as referenced in paragraph 2.5 of this policy.

3.6. All AFMS MTF PCEs and/or primary care clinics that are presently engaged in OA appointing at the time that this policy is established will review their current OA appointing practices and if necessary, revise their OA appointing processes accordingly to meet the requirements of this policy within six months of its effective date.

3.6.1. The general rule is that if a PCE and/or clinic uses the OPAC appointment type, it is recognized that they are engaged in some form of OA appointing. If they use the OPAC appointment type then they will have to comply this policy.

3.6.2. MTFs with PCEs and/or clinics engaged in OA appointing will provide information to their respective MAJCOMs in accordance with paragraphs 4.3.6 and 4.3.7 of this policy.

3.7. This policy is not written to interfere with OA appointing efforts in specialty or ancillary care treatment areas. These areas are encouraged to continue performing their OA appointing efforts to improve access to their beneficiaries. This policy does not govern OA appointing in Specialty or Ancillary areas.

4. Roles and Responsibilities.

4.1. Access To Care Program, Health Benefits Division, AFMSA/SGSA, Office of the Surgeon General will:

4.1.1. Receive all necessary information regarding MTFs, PCEs and/or clinics implementing or already engaged in OA appointing from the MAJCOMs.

4.1.2. Maintain a listing of all AFMS MTFs' PCEs and/or clinics engaged in OA appointing down to the MEPRS code level. This listing will be maintained on the Knowledge Exchange at https://kx.afms.mil/healthbenefits. Only those PCEs and/or clinics on the list will be measured using OA appointing metrics.

4.1.2.1. This list will be verified using electronic means to identify the presence of Open Access (OPAC) appointment type slots in PCEs and/or clinics schedules. Those sites with OPAC appointments found on schedules will be added to this list.

4.1.3. Act as the functional owner of all OA appointing performance measurement and/or metric activities in the AFMS.

4.1.4. Coordinate OA appointing performance measurement and metric development activities with the Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity, TRICARE Operations Center, interested panels of the Office of the Surgeon General and the Office of the Surgeon General, Health Modeling & Informatics Division.

4.2. Office of the Surgeon General, Health Modeling and Informatics Division will:

4.2.1. Develop ways to electronically identify OA sites, and develop and implement performance measures and/or metrics of OA appointing operations for display in the AFMS.

4.3. MAJCOM Surgeon Generals and Staffs will:

4.3.1. Develop guidelines and timelines to be followed by their respective MTFs wanting to implement OA appointing.

4.3.2. Develop criteria to determine if and when a prospective MAJCOM MTF can implement OA appointing at their location.

4.3.3. Review each AFMS OA Implementation and Sustainment Plan (attachment 1) submitted by their prospective MTFs and determine if MTFs are prepared to successfully implement and sustain OA appointing.

4.3.4. Forward on an as need basis, all necessary information to include the proposed start date of the MTF, PCEs, and/or clinic implementing OA appointing to the Access To Care (ATC) Program of the Health Benefits Division, (AFMSA/SGSA), Office of the Surgeon General.

4.3.5. Forward the information listed in 4.3.6, on an as needed basis, from MTFs that have PCEs and or clinics already engaged in OA appointing to AFMSA/SGSA, so that these can be accurately measured using OA metrics. The goal is that the listing of OA PCEs and/or clinics engaged in OA appointing will be kept current. Each time that a new PCE and/or clinic desiring to enter into OA appointing, the MAJCOM will forward the required information to AFMSA/SGSA. If an OA PCE and/or clinic is not on the OA list maintained by AFMSA/SGSA, it will not be measured using OA metrics.

4.3.6. MAJCOMs, upon receipt of this policy, will forward the following required information about all PCEs and/or clinics wanting to or presently engaged in OA appointing to AFMSA/SGSA:

4.3.6.1. MTF's name, base

4.3.6.2. MTF's Defense Medical Information System Identification Number (DMIS ID)

4.3.6.3. Applicable OA PCE and/or clinic name

4.3.6.4. Applicable OA PCE and/or clinic MEPRS code

4.3.6.5. Applicable OA PCE and/or clinic start date for OA appointing. (Date that OA metrics will be applied to the PCE and/or clinic).

4.3.7. Be responsible to maintain an accurate accounting of all PCEs and/or clinics engaged in OA appointing, notifying AFMSA/SGSA to add and or remove sites as needed.

4.3.8. Develop guidelines to migrate existing OA sites into compliance with this policy.

4.4. The Medical Group Commander will:

4.4.1. Be responsible for the overall success of OA appointing at his/her facility.

4.4.2. Ensure that their MTF staff performs a thorough analysis of OA appointing requirements by fully completing, signing and submitting, per MAJCOM guidance, the AFMS Open Access Implementation and Sustainment Plan (attachment 1) to his/her respective MAJCOM.

4.4.3. Ensure that their respective OA PCEs and/or clinics are adequately resourced to successfully perform OA appointing.

4.4.4. Ensure that their respective MAJCOM is appropriately informed of PCEs and/or clinics that implement OA appointing at their MTF, even though OA services have previously been implemented by other PCEs and/or clinics.

4.4.5. Ensure that OA staff is appropriately trained to support the successful implementation and sustainment of OA appointing.

4.4.6. Will within six months of the effective date of this policy, convert any PCE and/or primary care clinic performing OA appointing to the methodology contained in this policy beginning in Section 6.

5. OA Implementation and Sustainment Plan (Attachment 1) Submission Requirements:

5.1. MTFs considering implementation of OA appointing will submit the "AFMS OA Implementation and Sustainment Plan" to their MAJCOM, respective Multi-Market Office and TRICARE Regional Office (if applicable), prior to implementing OA appointing.

5.2. Timelines of submission of the "AFMS OA Implementation and Sustainment Plan" will be in accordance with MAJCOM guidelines, but within six months for all OA sites as stated in paragraph 3.6.

5.3. The "AFMS OA Implementation and Sustainment Plan" will identify those PCE names and the respective MEPRS codes of the PCE(s) and/or clinics that will be making the transition

to OA appointing. This plan will be signed by the MTF commander. Sites should be prepared to brief on how they plan to successfully undertake OA appointing to their respective MAJCOM. MAJCOMs will review the plan and coordinate with the MTF as required.

5.4. Once an MTF completes the plan and decides on a start date for its PCEs and/or clinics to move to OA appointing, the MAJCOM will notify AFMSA/SGSA (Health Benefits Division).

5.5. MAJCOMs will ensure the completion of subsequent plans for each additional PCE implementing OA appointing at an MTF. Specifically, if the same MTF adds additional PCE(s) and/or clinics, the MAJCOM will ensure that an AFMS OA Implementation and Sustainment Plan is completed and once approved to start OA appointing, will notify AFMSA/SGSA.

5.6. MTFs and MAJCOMs will maintain a record copy of their plan on file for use by other PCEs and or clinics wanting to engage in OA appointing and for inspection purposes.

6. AFMS Open Access Appointing Methodology. In order that consistency of service, measurement and metrics can be applied, all AFMS MTFs engaged in OA appointing will adhere to the following guidance:

6.1. Use of the Open Access (OPAC) Appointment Type. The OPAC standard appointment type will be used to offer patients same day acute, routine, wellness, or follow-up primary care services. Every effort will be made to allow patients to see their Primary Care Manager (PCM) on the same day that they request an appointment by using the OPAC appointment type. Not less than 60 percent of appointment slots on a PCEs and/or clinic's schedule engaged in OA appointing will be the OPAC standard appointment type. However, this practice does not open the clinic into a full "walk-in" type service. To the greatest extent possible, all of the patient's issues are addressed in a single visit to minimize the need for unnecessary future appointments/repeat visits. Patients may be routed through PCE Team or Triage Nurse for same day service if utilized, and if so, processes must be in place to ensure completion of those types of services by close of business, i.e. nurse triage processes must ensure patients get the same day care that they need on their first phone call by close of business. To search for the OPAC appointment type, appointing personnel must use the Category of ACUTE in the Composite Health Care System (CHCS) Managed Care Program (MCP) that is mapped to the 24-hour Acute Access To Care (ATC) Standard.

6.1.1. OPAC Appointment Type Scenario. Mrs. Jones has been experiencing a pain in her shoulder for a couple of days and calls the Medical Group (MDG) appointment line on Monday morning to schedule a visit with her PCM. The appointment clerk at the MDG, using the appropriate script, determines that she is a TRICARE Prime beneficiary enrolled to Dr. Smith and using the Acute ATC Category in CHCS, searches for OPAC appointments with Dr. Smith, offering a specific appointment at 1400 on Monday afternoon; Mrs. Jones accepts. The clerk books the appointment and provides Mrs. Jones with the appropriate instructions for her appointment.

6.2. Appointment Types Used For AFMS OA appointing. The standard appointment types "allowed" for OA appointing are OPAC, ROUT, PCM, WELL, SPEC, PROC, EST, GRP. A

majority of the slots (equal to or greater than 60 percent) on the schedule for OA PCEs and/or clinics will be coded with the OPAC standard appointment type. If the other "allowed" appointment types (other than OPAC) are utilized, they will be used in accordance with the operational definitions described in Appendix H, Commander's Guide for Access Success listed on the TRICARE Access Imperative Website at URL: http://www.tricare.osd.mil/tai/cguide.htm. These other "allowed" appointment types will assist clinic staffs in setting aside times to book patients for specific services. Per the functionality of CHCS, Acute, Routine, Wellness, Specialty and Future ATC Categories/CHCS Searches may have to be employed to search for and book these "allowed" appointment types. OA PCEs and/or clinics using all of these other appointment types may see these same ATC Categories on their ATC Summary Reports. It is at the discretion of the clinic to use one or all of the appointment types from this "allowed" standard appointment type group.

6.2.1. Use of the $ suffix on all "allowable" appointment types is at the discretion of the MTF, but it is not recommended as it lessens access, as $ suffix appointments are not viewable by TRICARE Online users.

6.3. Appointment Types Not Used For AFMS OA appointing.

6.3.1. The standard appointment type that will not be used for OA appointing is ACUT. OA appointing by its definition does not permit OA PCEs and/or clinics to use the ACUT appointment types on their templates or schedules.

6.3.2. Clerks are only permitted to use the Acute ATC Category/CHCS search to book OPAC appointments.

6.4. Good Backlog Appointment Slot Definition. A Good Backlog appointment slot will be used for patients who decline an offer for a same day OPAC appointment in favor of an appointment on a future date other than the day of the request, or for provider directed appointments to be scheduled at a future time, e.g. follow-ups, initial specialty visits, procedures, group appointments.

6.4.1. Good Backlog Appointing Scenario. Mrs. Brown has a son that needs a sports physical and calls the MDG Appointment Line on Tuesday morning to schedule a visit with his PCM. The appointment clerk at the MDG, using the appropriate script, determines that he is a TRICARE Prime beneficiary enrolled to Dr. Hart. Using the Acute ATC Category in CHCS, the clerk searches for OPAC appointments with Dr. Hart and offers a specific appointment at 1500 on Tuesday afternoon. Mrs. Brown declines this appointment, as her son will still be in school and the clerk offers a later appointment at 1530. Mrs. Brown declines again and asks if he can be seen on Thursday. The clerk then offers an appointment at 0730 on Thursday with Dr. Hart and Mrs. Brown accepts. The clerk documents the refusal using the prompts in CHCS, books the Good Backlog appointment and gives Mrs. Brown the appropriate instructions.

6.5. Good Backlog Templating and Scheduling Methods. The AFMS **recommends** 4 methods to template and schedule Good Backlog appointment slots. These methods consist of the exclusive use of OPAC, or OPAC-GDBL or EST-GDBL or a combination of one of these

first three methods and one, or all, of the "allowed" appointment types to include ROUT, PCM, WELL, SPEC, PROC, EST or GRP. So that consistency of process is maintained, it is recommended that OA MTFs are permitted to use only one of the four methods described below. It is recommended that that all OA PCEs and/or clinics at the same MTF should use the same method of booking Good Backlog appointments. Use of one of these four methods is not mandatory. OA PCEs and/or clinics may employ any method of templating, scheduling and booking Good Backlog appointments, however, the intent of what ever process that is used should provide consistency of method throughout the MTF.

6.5.1. Method One. Use OPAC appointment type only (OPAC). In this method MTFs will only use the OPAC appointment type without detail codes to template and schedule Good Backlog appointments. Using the Acute ATC Category/CHCS search, clerks will first search for and offer the patient an OPAC appointment on the same day. If a patient refuses a same day OPAC appointment, clerks will remain with the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an OPAC appointment not on the same day. If the OPAC appointment selected to be booked is not on the same day but is within the 24 hour, 1,440 minute, Acute ATC Standard, CHCS will annotate this booking as a Met on the ATC Summary Report. If an appointment is chosen outside the 24 hour, 1,440 minute, Acute ATC Standard, and there are available slots inside this standard, the clerk will document a patient refusal due to patient preference per the prompts in CHCS. CHCS will annotate this booked appointment as a Patient Refusal on the ATC Summary Report.

Method One Booking Script. OPAC Good Backlog Appointments:

STEP 1: Patient Calls, clerk finds out patient's enrollment status and PCM
No up-front specific needs are communicated by the patient.
Script:
CLERK: Hello my name is xxxxx, this is the xxxxx Clinic, do you need a medical appointment? If there is a need for a medical appointment, then the clerk will ask, "May I have your name and the last four digits of the sponsor's SSN? Who is your PCM? What is your team?" (Register patient and find PCM/PCE). (The clerk will not ask the patient what their specific want or need is.)

STEP 2: Clerk performs Acute Search, and offers patient an OPAC appointment for that same day. (The goal of this action is to try and book the patient on the same day that they contact the clinic for an appointment.
Script:
CLERK: Mrs. Jones, I have an appointment with Dr. Brown today at xxxx time.

STEP 3: If Mrs. Jones does not accept a same day appointment and requests another appointment not on the same day, the clerk will perform an additional search in the same Acute ATC Category/CHCS Search out past the end of the same day and provide the patient the next available appointment that is on the schedule with an OPAC appointment type.
Script:
CLERK: Mrs. Jones, I will look for other appointments starting tomorrow. I have an appointment for you tomorrow at xxxx time. (Or any time not on the same day that is acceptable to the patient.)

6.5.1.1. Advantages of OPAC only for booking good backlog:

6.5.1.1.1. Simple to template, only one appointment type for clerks to learn.

6.5.1.1.2. Customer focused, as there is no differentiation between OPAC same day and OPAC Good Backlog appointment slots. OPAC is used for same day or Good Backlog appointments.

6.5.1.1.3. Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care Category/CHCS search. Most times when booked, a Met or a patient refusal will be documented.

6.5.1.1.4. Can be displayed on TRICARE Online (TOL) appointing schedules.

6.5.1.2. Disadvantages of OPAC:

6.5.1.2.1. There is no upfront template and schedule planning to identify the proper number or mix of Good Backlog appointments and same day appointments.

6.5.1.2.2. There is no clear identification on the schedule of Good Backlog appointments for clerks or providers.

6.5.1.2.3. There is a potential that there will be no preservation of same day access, meaning all appointments on future days will be booked.

6.5.1.2.4. TOL appointment display does not differentiate between same day and Good Backlog appointments.

6.5.1.2.5. Clerks cannot perform an appointment search by detail code.

6.5.1.2.6. There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC) as they are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool of the TRICARE Operations Center URL: http://www.tricare.osd.mil/tools.

6.5.2. Method Two. Use OPAC appointment type with the Good Backlog (GDBL) detail code (OPAC-GDBL). In this method MTFs will identify Good Backlog appointments on their templates and schedules by using the OPAC appointment type in conjunction with the GDBL detail code. Using the Acute ATC Category/CHCS search, clerks will first search for and offer the patient an OPAC appointment on the same day. If a patient refuses a same day OPAC appointment, clerks will remain in the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an OPAC-GDBL slot not on the same day. If the OPAC-GDBL appointment slot is booked and is not on the same day of the current search, but is within the 24 hour, 1,440 minute, Acute ATC Standard, CHCS will annotate this booking as a Met on the ATC Summary Report. If an OPAC-GDBL appointment slot is chosen

outside the 24 hour, 1,440 minute, Acute ATC Standard, and there are available slots inside this standard, the clerk will document a patient refusal due to patient preference per the prompts in CHCS. CHCS will annotate this booking as a Patient Refusal on the ATC Summary Report.

Method Two Booking Script. OPAC-GDBL Good Backlog Appointments: can to mays

STEP 1: Patient Calls, clerk finds out patient's enrollment status and PCM
No up-front specific needs are communicated by the patient.
Script:
CLERK: Hello my name is xxxxx, this is the xxxxx Clinic, do you need a medical appointment? If there is a need for a medical appointment, then the clerk will ask, "May I have your name and the last four digits of the sponsor's SSN? Who is your PCM? What is your team?" (Register patient and find PCM/PCE). (The clerk will not ask the patient what their specific want or need is.)

STEP 2: Clerk performs Acute Search, and offers patient an OPAC appointment for that same day. (The goal of this action is to try and book the patient on the same day that they contact the clinic for an appointment.
Script:
CLERK: Mrs. Jones, I have an appointment with Dr. Brown today at xxxx time.

STEP 3: If Mrs. Jones does not accept a same day appointment and requests another appointment not on the same day, the clerk will perform an additional search in the same Acute ATC Category/CHCS Search out past the end of the same day and provide the patient the next available appointment that is on the schedule with an OPAC appointment slot with a good backlog, GDBL detail code.
Script:
CLERK: Mrs. Jones, I will look for other appointments starting tomorrow. I have an appointment for you tomorrow at xxxx time. (Or any time not on the same day that is acceptable to the patient.)

6.5.2.1. Advantages of OPAC-GDBL:

6.5.2.1.1. Allows upfront template and schedule planning, e.g. a 70 percent sameday/30 percent Good Backlog appointment ratio can be maintained.

6.5.2.1.2. Easy for clerks and providers to identify slots on templates and schedules.

6.5.2.1.3. Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care/CHCS search. Most times when such appointments are booked, a met or patient refusal will be documented.

6.5.2.1.4. Appointment booking is faster since appointment types do not have to be changed.

6.5.2.1.5. An appointment search by detail code can be performed to find Good Backlog appointments.

6.5.2.1.6. OPAC-GDBL does not have to be frozen, since they are easily identified.

6.5.2.2. Disadvantages of OPAC-GDBL:

6.5.2.2.1. There is less patient choice of Good Backlog appointments with this method.

6.5.2.2.2. There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC-GDBL) are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool.

6.5.2.2.3. More templating and scheduling work is required to add the detail code GDBL to the OPAC appointment type.

6.5.2.2.4. TOL will not display OPAC appointments with the GDBL detail code.

6.5.3. Method Three. Use the Established appointment type (EST) with the GDBL detail code (EST-GDBL). In this method MTFs will identify Good Backlog appointments on their templates and schedules by using the EST appointment type in conjunction with the GDBL detail code. Using the Acute ATC Category/CHCS search, clerks will first search for and offer the patient an OPAC appointment on the same day. If a patient refuses a same day OPAC appointment, clerks will remain with the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an EST-GDBL slot not on the same day. If the EST-GDBL appointment slot is booked and is not on same day as the search, but is within the 24 hour, 1,440 minute, Acute ATC Standard, CHCS will prompt the user to change the appointment type from EST to OPAC and will annotate this booking as a Met on the ATC Summary Report. If an EST-GDBL appointment slot is chosen outside the 24 hour, 1,440 minute, Acute ATC Standard, the clerk will be prompted to change the appointment type from EST to OPAC and will document a patient refusal due to patient preference per the prompts in CHCS. CHCS will annotate this booking as a Patient Refusal on the ATC Summary Report.

Method Three Booking Script. EST-GDBL Good Backlog Appointments:

STEP 1: Patient Calls, clerk finds out patient's enrollment status and PCM
No up-front specific needs are communicated by the patient.
Script:
CLERK: Hello my name is xxxxx, this is the xxxxx Clinic, do you need a medical appointment? If there is a need for a medical appointment, then the clerk will ask, "May I have your name and the last four digits of the sponsor's SSN? Who is your PCM? What is your team?" (Register patient and find PCM/PCE). (The clerk will not ask the patient what their specific want or need is.)

STEP 2: Clerk performs Acute Search, and offers patient an OPAC appointment for that same day. (The goal of this action is to try and book the patient on the same day that they contact the clinic for an appointment.
Script:
CLERK: Mrs. Jones, I have an appointment with Dr. Brown today at xxxx time.

STEP 3: If Mrs. Jones does not accept a same day appointment and requests another appointment not on the same day, the clerk will perform an additional search in the same Acute ATC Category/CHCS Search out past the end of the same day and provide the patient the next available appointment that is on the schedule with an established, EST appointment type with a GDBL detail code. The clerk will have to change the EST appointment type to OPAC to complete booking this appointment.
Script:
CLERK: Mrs. Jones I will look for other appointments starting tomorrow. I have an appointment for you tomorrow at xxxx time. (Or any time not on the same day that is acceptable to the patient.)

6.5.3.1. Advantages of EST-GDBL:

6.5.3.1.1. Allows upfront template and schedule planning, e.g. a 70 percent sameday/30 percent Good Backlog appointment ratio can be maintained.

6.5.3.1.2. Easy for clerks and providers to identify slots on templates and schedules.

6.5.3.1.3. EST-GDBL slots are easy to freeze and unfreeze.

6.5.3.1.4. Separates provider directed follow-up (EST) slots from patient wanting a Good Backlog appointment (EST-GDBL).

6.5. 3.1.5. EST-GDBL allows for an easier measure of usage. These appointment slots are a different standard appointment type from the same day OPAC appointment type and can be differentiated on various canned CHCS reports or on the Template Analysis Tool.

6.5.3.2. Disadvantages of EST-GDBL:

6.5.3.2.1. There is less patient choice of Good Backlog appointments.

6.5.3.2.2. More templating and scheduling work is required to add the detail code GDBL to the EST appointment type.

6.5.3.2.3. TOL will not display EST appointments with the GDBL detail code.

6.5.3.2.4. Clerks are required to change the EST appointment type to OPAC in order to book the appointment. CHCS requires the appointment type to correspond with an initial Acute Access To Care Category/CHCS search. There is a need to issue security keys for this activity.

6.5.4. Common Elements of Methods 1-3 for booking Good Backlog.

6.5.4.1. If OA PCEs and/or clinics decide to opt for either method 1, 2, or 3, either OPAC (method 1), or OPAC-GDBL (method 2), or EST-GDBL (method 3) can only be used to template and schedule good backlog services such as initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. No other appointment types can be used.

6.5.4.2. If OA PCEs and/or clinics opt to use either method 1, 2, or 3, there can only be two standard appointment types on the schedule depending on which method of good backlog templating and scheduling is used. These would be OPAC exclusively or a combination of OPAC and EST.

6.5.4.3. There will be no differentiation made on the schedule for good backlog services by appointment types when using either method 1, 2, or 3. However, schedulers could create slots with longer or shorter time periods or use detail codes to assist clerks discern those

slots that could be used for different types of services. Clerks will have to be trained to understand the difference, e.g., an OPAC-GDBL slot that is 45 minutes long may be used for a procedure or an initial specialty visit. Or an OPAC appointment that has 10 available slots at the top of the hour, and is one hour long and is coded with education detail codes could be used for a group service appointment. Clerks could be trained to split and/or join these appointments to allow for more patients to be booked depending on how far out into the future slots are available on the schedule.

6.5.4.4. A risk of only using either method 1, 2, or 3 for templating and scheduling good backlog appointments is that there will be no appointments slots available to patients requiring the following types of services: initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. It is a risk because these slots are not readily identifiable to the clerk.

6.5.5. Method Four. Allows schedulers to use a combination of either method 1, 2, or 3 as stated above for booking good backlog and using one or all of the "allowed" standard appointment types on the schedule to include PCM, WELL, SPEC, PROC, EST or GRP.

6.5.5.1. If using method 4, schedulers will use the standard appointment types of ROUT, PCM, WELL, SPEC, PROC, EST or GRP in accordance with the definitions as listed in Appendix H of the Commander's Guide for Access Success.

6.5.5.2. The advantages of using one or all of the appointment types to include ROUT, PCM, WELL, SPEC, PROC, EST or GRP allows for their immediate recognition by appointment clerks to schedule various services that the PCE and/or clinic offers other than OA or good backlog appointments. Templates and schedules can be easily apportioned to allow for advanced planning of services.

6.5.5.3. If using method 4, clerks can use two methods to search for and book ROUT, PCM, WELL, SPEC, EST and GRP appointments. They are:

6.5.5.3.1. Use the Acute ATC Category to search for and book these appointments. By using the Acute ATC Category/CHCS search, the clerk will be required to change the appointment type of ROUT, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type. If there are no appointments of any of these types available on the same day, a patient refusal will be documented. When using this searching method, OA PCEs and/or clinics may want to additionally code the slot with a GDBL detail code, to tell the clerk that these ROUT, PCM, WELL, SPEC, PROC, EST, or GRP appointment slots can be searched for and booked using the Acute ATC Category/CHCS search instead of their traditional appointing ATC Category.

6.5.5.3.2. Use the appropriate/traditional ATC Category/CHCS Search. If the clerk learns at the beginning of the patient request for service a need for a specialty care consult request, or for a provider directed follow-up after an initial visit with the PCM, or if the PCE and/or clinic conducts a program such as "Right Start," or for a provider directed Group visit or class, the clerk can conduct the appropriate traditional search to book the needed appointment.

The clerk can use the appropriate Routine, Wellness, Specialty, or Future ATC Category/CHCS Search. By doing so, there is no need for the clerk to change the appointment type from ROUT, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type.

Method Four Booking Script. Method One, Two or Three in Combination with other "allowed" appointment types:

STEP 1: Patient Calls, clerk finds out patient's enrollment status and PCM. No up-front specific needs are communicated by the patient.
Script:
CLERK: "Hello my name is xxxxx, this is the xxxxx Clinic, do you need a medical appointment?" If there is a need for a medical appointment, then the clerk will ask, "May I have your name and and the last four digits of the sponsor's SSN? Who is your PCM? What is your team?" (Register patient and find PCM/PCE). The clerk WILL ask, "What is the reason for your appointment?" (By asking this question, the clerk will determine what the appropriate traditional CHCS search is to correspond with this patient's need and to determine when the appointment should be booked.) This search may be Acute, Wellness, Specialty or Future, depending on the patient's need.

STEP 2: Clerk performs the appropriate Acute, Wellness, Specialty, or Future Search, that matches the patient's need and offers the patient the appropriate appointment slot and type to include OPAC, ROUT, PCM, WELL, SPEC, PROC, GRP, and EST for the appropriate ATC Standard based on the appointment search. (The goal of this action is to try and book the patient based on the patient's need, and match the need to the correct ATC Category and book the appointment in the appropriate amount of time.
Script:
CLERK: "Mrs. Jones, I have booked you a PAP smear an appointment for Thursday at xxxx time." (To complete this booking action, the clerk picked a Wellness ATC Category and chose a WELL standard appointment type with detail codes of GDBL, PAP, FE within 28 days.

6.6. Guidance on Use of Detail Codes.

6.6.1. In accordance with CHCS functionality, up to 4 detail codes can be used on each appointment slot. OA PCEs and/or clinics are encouraged to use detail codes sparingly. Detail codes are used to restrict access to the appointment slot for a particular need such as designating that slot for a particular procedure, reserving a slot for a specific class, or to permit only a certain group of beneficiary to be booked into the slot, such as Active Duty or TRICARE Prime.

6.6.2 Use of detail codes to restrict access to other than Active Duty and TRICARE Prime beneficiaries may be beneficial to OA PCEs and/or clinics to ensure that the mandates from the 32 Code of Federal Regulations (U.S. Law) 199.17 are maintained for these enrolled beneficiaries.

6.6.3. Use of detail codes will be in accordance with Appendix M of the 'Commander's Guide for Access Success."

6.6.4. Two detail codes are meant to facilitate OA appointing. They are to be used as follows:

6.6.4.1. GDBL/Good Backlog Detail Code. This detail code will be used to code a Good Backlog appointment slot. This slot will be used for patients who decline an offered same day OPAC appointment in favor of an appointment on a future date other than the same day of

the request, or provider directed future appointments, e.g. follow-ups, initial specialty visits, procedures, group appointments. The GDBL detail code can be used in combination with the ROUT, PCM, WELL, SPEC, PROC, EST or GRP standard appointment types "allowed" for OA appointing.

6.6.4.2. CB/Cross Book Detail Code. The CB detail can be used to designate appointment slots in other OA PCEs and/or clinic PCM's schedules for patients who are unable to get care with their own PCM. The CB detail code should only be used during the absence of one or more members of the PCE and/or clinic to ensure that beneficiaries will not be without access to care. The CB detail code appointment slots should be added to "floater/fill-in" provider's or regular PCE and/or clinic staff provider's schedules to equal the same number of daily slots that would have been made available if the missing provider(s) slots were on the schedule, e.g. if the missing provider(s) daily available slots were 25, then 25 CB detail coded slots should be added to "floater" or staff provider's schedules to maintain the same number of slots for the cared for population.

6.7. Freezing Appointments.

6.7.1. Freezing appointments is a local MTF decision. Freezing appointment slots help protect OPAC appointments from being used in the future and not being available for same day booking.

6.7.2. Appointing staff of OA PCEs and/or clinics that choose to freeze appointment slots will never tell patients to call back due to not being able to see and or book frozen appointments. Ample number of unfrozen same day and Good Backlog appointments on future days will be available to booking agents, preferably 28 days, or more, out. Patients seeking care should be allowed an ample choice of same day or Good Backlog appointments, within ATC standards and/or to meet their needs, during the first request.

6.7.3. It is highly recommended that appointment booking agents have the security keys to unfreeze slots during the daily process of booking appointments.

6.7.4. Freezing Appointments Scenarios. As follows are two scenarios that explain the benefits and the fouls created by freezing appointment slots if freezing is employed.

6.7.4.1. Benefits of Freezing Appointments. The GPM at Right Way AFB clinic is using the OA appointing methodology. The clinic exclusively uses the standard appointment type of OPAC to identify all of its appointment slots on its schedules. Wanting to maintain a ratio of 70 percent of its slots to be booked on the same day, the GPM uses the freeze function in CHCS to prevent clerks from booking these OPAC standard appointment slots out into the future. Every evening for the next day, the GPM uses the reconfiguration function of CHCS to unfreeze all of these OPAC slots to permit appointing clerks to book when the appointment telephone lines open at 0630 the next morning. Conversely, the GPM uses the GDBL detail code on 30 percent of the clinic's OPAC slots to identify them as Good Backlog appointments. He never freezes these OPAC-GDBL slots. This way the GPM makes sure that when a patient requests an appointment and does not want to be seen on the same day, the patient's request is

resolved immediately at any time during the booking day, without having to make the patient call back or asking a triage nurse to call the patient to resolve his/her needs.

6.7.4.2. Foul Associated with the Freezing of Appointments. Mrs. Smith is in need of a routine physical exam to gain employment at the base day care center. She calls the Wrong Way AFB MDG appointment line on Tuesday at 1400 to schedule a visit with her PCM. The appointment clerk at the Wrong Way clinic, using the appropriate script, determines that she is a TRICARE Prime beneficiary enrolled to Dr. Day. Using the Acute ATC Category in CHCS, searches for OPAC appointments with her PCM that same day. Not finding any available appointments with Dr. Day, the clerk asks Mrs. Smith if she would like an appointment with any other providers in the PCE for that same day. Mrs. Smith states that she does not want any appointments offered for that day, and would prefer an appointment on Friday with her PCM. The clerk, not granted the security keys to open and book these frozen appointments, tells Mrs. Smith that she cannot book any appointments with Dr. Day on Friday, because the schedules are "not opened" that far in advance. The clerk (following clinic protocol) then asks Mrs. Smith if she would prefer to have a telephone consult given to the team nurse to call Mrs. Smith back to discuss her Friday appointment request or if Mrs. Smith would prefer to call the clinic back on Friday to book her appointment. Mrs. Smith, not wanting to call back, agrees to have the team nurse call her back. The clerk then completes the unbooked appointment request in CHCS and a telephone consult for the team nurse. At 1730, after calling back 20 other patients that wanted future appointments, the team nurse tries to call Mrs. Smith. However, the information provided by the clerk is not current and the team nurse finds that Mrs. Smith's listed telephone number has been disconnected. Mrs. Smith is never contacted. Mrs. Smith, still needing her physical, walks-in to the clinic on Monday to see if she can get her needed health care. After much negotiation, the clinic staff works Mrs. Smith into a slot at 1600. With the clinic running late that day, Mrs. Smith is finally seen at 17:30.

6.8. Available Appointments, Control of Schedules, Start and End of Work Day.

6.8.1. OA PCEs and/or clinics will ensure that there is a continuous supply of 28 days worth of available appointments on their schedules. This means that at any time during a given month, when a patient calls, appointment clerks or TRICARE Online (TOL) will have a choice of 28 days or greater of available appointments into the future to choose from for booking Good Backlog appointments. Decisions to freeze OPAC appointment slots is a local decision, but Good Backlog appointments will not be frozen to permit choice by clerks, TOL and patients.

6.8.2. PCE leaders and/or clinic chiefs will maintain control of the templates and schedules of PCMs within his/her PCE in consultation with the GPM. This responsibility includes the oversight and control of PCMs' TDY, leaves and administrative time that takes away from available clinic time. This responsibility also includes the control of numbers of appointment slots available and the opening and freezing of schedules. Templates will be created, revised and maintained as directed by the PCE leader and/or clinic chief.

6.8.3. The administration of OA templates and schedules will ensure timely access to appointments and consultations, a fit and medically ready force, and the delivery of high quality clinical care.

6.8.4. The PCE leaders and/or clinic chiefs will have written contingency plans in place to provide guidance during the event of unexpected provider absences, or unanticipated increases in patient demand. In addition, these leaders will ensure that clinic business hours are maintained to support AFMS Open Access Appointing focus of "Doing Today's Work by Close of Business Today," even if it means opening earlier or closing later.

6.9. PCE Continuity Guidance.

6.9.1. The AFMS OA appointing model assumes that OA PCEs and/or clinics have an assigned panel of patients to maintain maximum continuity. Continuity measures the likelihood that a patient sees his/her own PCE when he/she seeks care and is important to the PCM, PCE and the patient's health care quality and satisfaction. Two perspectives of continuity exist: patient (how often a patient actually sees his/her assigned PCM when receiving care) and to the PCE (of patients seen, how many are really the PCE's).

6.9.2. It is the PCE leader and/or clinic chief's responsibility in collaboration with the GPM to decide on the appropriate level and to monitor PCE continuity. In order to provide both daily access and continuity, each PCM working as a team within his/her PCE must have the capacity to provide for the daily demand of his/her enrolled panel and that of the PCE. It must be possible to distribute enrollees among providers in such a way that each PCE's panel size is proportional to that team's capacity. If there are a substantial number of non-enrollees, their impact on the capacity of PCE must be clarified.

6.10. TOL Guidance.

6.10.1. The procedures for scheduling and displaying appointments on TOL will be in accordance with TRICARE Management Activity TOL program manuals and web based training classes.

6.10.2. TOL OA appointing processes will be overseen by the MTF TOL Project Manager and the TOL Appointing Supervisor, if so designated.

6.10.3. OA PCEs and/or clinics with OPAC appointment types on their schedules will set the radio buttons on the TOL MTF administrator screen for display of timeframes of TOL OPAC appointments to menu options (1) "Same Day" which displays all available OPAC appointments until 2400 the same day, or (2) "Next 24 Hours" which displays all OPAC appointments available during the next 24 hours. Option (3) "Today and Tomorrow" is not permitted to be used by AFMS OA sites.

6.10.4. Appointment slots that have the $ suffix on the appointment type or the GDBL and/or CB detail codes cannot be displayed to TOL users even though the WEA (web enabled) detail code is also used in another detail code slot.

6.11. Bad Backlog.

6.11.1. Definition of Bad Backlog. Bad Backlog occurs when the OA PCE and/or clinic does not have the capacity to allow a patient requesting same day service to receive care on the same day and must therefore book an appointment on a future date. NOTE: "book an appointment on a future date" is an expression of time and does not refer to the booked to future ATC Category/function in CHCS.

6.11.1.1. Bad Backlog Scenario: SSgt Powell needs to be seen for an earache and calls the MDG appointment line at 0830 on Thursday morning to schedule a visit with his Primary Care Manager. The appointment clerk, using the appropriate script, determines that he is TRICARE Prime and enrolled to Dr. Sharp. Knowing that Dr. Sharp is unavailable, the clerk asks SSgt Powell if he would like to be seen by another provider and SSgt Powell accepts. Using the Acute ATC Category in CHCS, the clerk searches for OPAC appointments with the other PCMs in the PCE and finds no available appointments. The clerk then communicates this lack of appointments to the PCE nurse who tries to work SSgt Powell into an appointment on the same day schedule, but cannot. The clerk then tells SSgt Powell there is nothing available on Thursday and offers an appointment at 0800 on Friday with Dr. Blocker. SSgt Powell accepts the appointment and the clerk provides the appropriate instructions. NOTE: In this scenario, the MTF met the acute ATC standard of 24 hours, however, it did not meet the same day standard of AFMS Open Access and bad backlog occurred.

7. Guidance on OA Marketing.

7.1. The decision to market open access directly to the patient and/or to base leadership will be the choice of the MTF commander. Experience has shown that marketing OA in this manner has advantages and disadvantages.

7.2. Regardless of what marketing strategy that is employed, all MTFs employing OA must continue to deliver care that is within the 32 CFR 199.17 ATC standards.

7.3. Each MTF must employ a marketing strategy that is tailored to the population it serves and allows for success of its OA program.

7.4. "No Marketing" Strategy Considerations.

7.4.1. Many MTFs that have implemented OA decided to simply market the 1-7-28 day access promise and keep the appointing strategy transparent. Other MTFs marketed only when the new OA practices had a reasonable success rate and the transition period had been established and proven. It was their decision that premature marketing and advertising served only to confuse beneficiaries or engender unsustainable expectations.

7.4.2. MTFs that employed this "no marketing" strategy made all activities during the OA transition period invisible to the beneficiary. They decided that the only thing that patients should notice was that their ability to get an appointment on the same day had greatly improved.

7.4.3. A "no marketing" OA strategy does not eliminate the requirement for an MTF informing its MAJCOM of its effort as required by this policy

7.5. Partial or Total Marketing Strategy Considerations.

7.5.1. MTFs will need to be careful as to how they label their OA program, as it influences patient and base leadership behavior and/or expectations. Recommended labels are Open Access or Same Day appointing. In either case, the AFMS OA definition and delivery expectation applies. Any variation from this policy cannot be marketed as either open access or same day appointing and the OPAC appointment type should not be used in these circumstances. MTFs cannot use the open access appointing method to open their clinics up into a full walk-in service.

7.5.2. MTFs may want to consider marketing only to the base leadership and not to their population.

7.5.3. If marketing OA directly to patients, MTFs should use the AFMS OA appointing definitions as stated in paragraphs 1.2 and 6.1 above. This will assist MTFs to fully describe the level service that they are offering, ensuring that consistency exists from base to base and patients are fully informed.

7.5.4. MTFs may want to request support from base leadership as it works down backlog during the transition from traditional appointing to OA appointing by minimizing base taskings for support. Another possible option to assist in working down the backlog is to request if the MTF can "buy down" backlog by employing resource sharing providers, which would help with staff not being overworked and burned-out prior to OA implementation and gives time for training staff on new processes.

7.5.5. A possible way to market OA is to let stakeholders know that the "MTF is transitioning to a new method of offering appointments to improve its ability to deliver on 1-7-28 day access standards."

8. Measures of OA Appointing Performance.

8.1 OA PCEs and/or clinics are encouraged to develop local measures to monitor the success of their OA appointing activities.

8.2. Typical indicators of OA effectiveness include, but are not limited to, measuring/ monitoring appointment availability, patient demand, PCE continuity, panel size, provider productivity, no-show rates, PCE/clinic cycle times, and patient and staff satisfaction.

8.3. Examples of these measures are included in the reference documents listed in paragraphs 2.2, 2.3, 2,4 of this policy.

9. Open Access Training Resources. The MTF Commander is responsible for ensuring MTF personnel are adequately trained in OA appointing.

9.1. MTF training offices should provide initial and sustainment training on the goals and objectives of OA appointing. Special attention needs to be paid to all team member's individual responsibilities assigned to the PCEs and or clinics employing OA appointing, such as templating and scheduling practices, booking scripts, and practice strategies that are germane to OA appointing.

9.2. Recommended resources include open access policy documents, briefings and information papers listed on the Knowledge Management Exchange at https://kx.afms.mil/healthbenefits and the TRICARE Access Imperatives website at http://www.tricare.osd.mil/tai.

9.3 Other training events/courses may be available throughout the year such as the Access Improvement Seminars. Announcement of these seminars come through MAJCOM TRICARE POCs and/or GPM channels.

9.4. Other courses, such as the GPM course and the Health Care Optimization course offered remotely or at Sheppard AFB also provide information on OA appointing.

9.5. There is additional training available from civilian organizations.

10. Metrics of OA Appointing Processes. The AFMS will globally monitor OA activities with 2 metrics. These include a same day access metric and a patient satisfaction survey metric. Performance of OA PCEs and or clinics will be measured as follows:

10.1. Same Day Access metric.

10.1.1. Understanding that OA is doing today's work today, same day access will be monitored for all identified OA PCEs and/or clinics throughout the AFMS in MEPRS codes stated in paragraph 3.3 of this policy. Success (green status) will be achieved when a proportion of 60 percent or greater of all appointments requested and booked for a given month are requested and booked on the same day.

10.1.2. Same day equates to anytime appointments are requested and booked during 0000 to 2359 on the same calendar day. Examples of same day and not on the same day are:

10.1.2.1. Same day equals an appointment requested at 1000 on 1 August 2004 and booked into an appointment at 1400 on 1 August 2004.

10.1.2.2. Not on the same day equals an appointment requested at 1000 on 1 August 2004 but not booked until 0900 on 2 August 2004.

10.1.3. Data for this metric will be derived from extracting appointment records from the patient appointment files of CHCS. Metric will be computed as follows:

Numerator: Number of appointment records where appointment requested date is the same calendar date as its final booked status to include kept, no show, left without being seen (LWOBS), patient cancel, facility cancel or pending, for the monthly reporting period.

Denominator: All appointment records requested and booked with a final booked status of kept, no show, LWOBS, patient cancellation, facility cancellation and pending for the same monthly reporting period. This includes all appointments requested and booked on the same day AND requested on one calendar day and booked on a later day.

10.1.3.1. Example Computation of Same Day Access:

```
DMIS ID: 123, Sample AFB, Gold PCE, Clinic: Family Practice MEPRS Code: BGAA
                        Report Period:  1-31 May 05

NUMERATOR:   1115 appointments requested and booked on the same calendar day
DEMONINATOR: 1537 total appointments requested and booked for the month

SAME DAY PERCENTAGE: 72.5%   STATUS:   GREEN  ≥ 60%
```

10.1.4. The Same Day Access metric does not use any of the measures reflected on the ATC Summary Report. It is a measure of same day access in OA PCEs and clinics engaged in OA appointing.

10.2. Service Delivery Assessment (SDA) Question.

10.2.1. The AFMS has developed a patient satisfaction questionnaire to gauge a caller's satisfaction with the telephone appointing process effectiveness to include OA PCEs and/or clinics.

10.2.2. The question identifies OA PCEs and/or clinics that are not offering Good Backlog appointments to patients who expect a future appointment preference or, those clinics which are abusing the freezing of appointments and instructing their patients to call back later to book appointments other than the day they call.

10.2.3. The SDA question is: "When you arranged your appointment over the telephone, were you able to schedule the appointment you needed, when you needed it, during your first call?"

10.2.4. It is hoped that this SDA question when used with the other access measures will provide a more complete picture of an MTF's access. Results from this measure should be compared and contrasted to the other MTF's P2R2 access to care scores. If high P2R2 access to care scores and low customer satisfaction scores with "first call resolution" are being received, further investigation and analysis of the MTF's booking practices may be warranted. Review of

nurse triage processes, and un-booked appointment data may provide more understanding of these inconsistencies and allow for better compliance with this policy.

11. Questions. Questions on this policy can be directed to Maj Mark Meersman, AFMS Access Program Manager at DSN 761-6193, commercial (703) 681-6193, or email at mark.meersman@pentagon.af.mil.

Attachment 1:
Air Force Medical Service Open Access Implementation and Sustainment Plan, dated 1 Oct 04

Air Force Medical Service
Open Access
Implementation And Sustainment Plan

1 October 2004

xx Medical Group
Sample AFB, Sample State
Date

Instructions for Completing this Document:

Understand the Definition. The first hurdle that potential Open Access (OA) sites need to cross is to understand the AFMS definition of OA appointing. This definition is universal throughout the AFMS. There are no variations or MTF-specific versions of AFMS OA appointing. The below definition is the foundation for consistent OA service to all AFMS beneficiaries.

> **AFMS Definition of Open Access Appointing**. AFMS OA is a process of developing schedules and booking medical appointments designed to offer each patient requesting Primary Care services, a same day appointment (by close of MTF business day). The primary principle of "Do today's work by close of business today" is the foundation of AFMS OA appointing. However, if the patient does not desire a same day appointment, appointments that meet TRICARE access standards on ensuing days will be offered. MTFs using OA appointing will give patients an appointment during their initial request or telephone call (first call resolution).

Understand the Commitment. If a potential site cannot or will not adhere to the above definition, there is no need to complete this plan. These sites should continue to appoint patients using the traditional method. However, if sites fully understand the definition and want to make the commitment to providing the level of service as stated in the definition, then they should complete this OA Implementation and Sustainment Plan.

Directions for completing this plan.
The AFMS OA Working Integrated Project team has developed this OA Implementation and Sustainment plan to assist sites to be successful in their pursuit of implementing and sustaining OA appointing at their MTFs. Sites contemplating OA appointing will submit this OA Implementation and Sustainment Plan to their respective MAJCOM, Multi-Market Office and TRICARE Regional Office (if applicable).

Specifically, sites will use this plan and its methodology to analyze their ability to successfully implement, sustain and/or to come into compliance with the AFMS OA Policy Guidance. Sites that are already engaged in some form of OA appointing will have six months from the effective data of the AFMS OA Policy to submit their plan. These sites may use the applicable contents of an OA business plan that were submitted in past, but all of the parts of this document must be addressed and completed with current information. In either case, MTFs will need to check with their respective MAJCOMs to see if there are any additional submission requirements and to ascertain how far in advance this plan will need to be submitted prior to an MTF's "Go Live" date for OA appointing.

All parts of this plan, to include all paragraphs listed in the table of contents, will be addressed and completed. The level of detail is at the discretion of the facility. This OA Implementation and Sustainment Plan will identify the Primary Care Elements (PCEs) by name and their respective Medical Expense Performance Reporting System (MEPRS) codes making the transition to AFMS OA appointing. The plan will need to be signed by the MTF commander. Sites should be prepared to brief their respective MAJCOM on how they plan to successfully undertake Open Access. MAJCOMs will review the plan and coordinate with the MTF as required prior to the MTF starting OA appointing.

By completing all parts of this plan, the MTF will be able to fully analyze their present and future business processes and make an informed decision as to their MTF's potential success in engaging in OA appointing. By being fully informed, all potential OA appointing MTFs will enter into this very demanding change fully prepared to meet the expectations of AFMS OA appointing.

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1. Background for OA. In this first section the MTF will describe its goals, expectations, and support for the program.

1.1. Describe your MTFs Expectations and Goals.

Discuss your MTF's understanding of the advantages, disadvantages and anticipated benefits OA appointing will offer your MTF patients and staff. Identify your overall goals in the areas of quality, access and cost and how your MTF will measure success, i.e. how will your MTF know if it is doing well at "Doing today's work today?"

1.2. Discuss Purpose and Senior Leadership Support.

Describe the reason(s) your facility is planning to implement AFMS OA appointing. Describe how this decision was made and what roles senior leadership played to include adjusting staff, tailoring policies, and providing resources to successfully implement and sustain AFMS OA appointing at your MTF.

1.3. Identify your Physician Champion.

Describe his/her role to the success of the program. Provide how long he/she will be remaining in his/her present duty position/assignment.

1.4. Discuss your MDG's previous performance with Access To Care (ATC).

1.4.1. Discuss your present Booked to Acute ATC Summary Report Scores.
1.4.2. Discuss your present Booked to Routine ATC Summary Report Scores.
1.4.3. Discuss your present Booked to Future ATC Summary Report Scores.
1.4.4. Discuss your present patient refusal scores for Booked to Acute, and Routine on the ATC Summary Report.

1.5. Describe the membership of your OA Implementation Team.

Provide names and positions of each team member. Your team at a minimum should include personnel from the following areas:

1.5.1. Team leader if not the Physician Champion
1.5.2. Provider (Physician Champion; see above)
1.5.3. Nursing and/or Health Care Integrator
1.5.4. Administration (Group Practice Manager)
1.5.5. Template manager if assigned
1.5.5. Administrative Tech/Records Management (4A0X, Health Services Manager)
1.5.6. Medical Technician (Active Duty AFSC)
1.5.7. Appointing Staff Member(s)
1.5.8. Ancillary Staff Member(s)

1.6. Identify the scope of the project and your MTF's "Go Live" date.

You will identify the "Go Live" date for each of your targeted Primary Care Element(s) (PCE) or Clinic(s) that will be converted to OA appointing. Provide PCE's or Clinic's name and its MEPRs code(s).

1.7. Present appointing practices.

In the paragraphs below describe the appointing practices of these PCE(s) or Clinic(s) identified above:

1.7.1. What process for searching for and booking appointments is used?

1.7.2. What appointment types and detail codes are used?

1.7.3. Are there scripts or algorithms on hand for appointing agents to use?

1.7.4. How are provider absences covered?

1.7.5. What is the training level and competency of appointing agents to include contract, active duty, and/or civilian appointing personnel?

1.7.6. How far in advance are schedules available for booking?

1.7.7. How are templates and schedules developed and controlled?

1.7.8. Is your system for appointing centralized or decentralized?

1.7.9. What are your medical records location(s) and rate of their availability?

1.7.10. What is your clinical and support staff availability?

1.7.11. What is your customer satisfaction with present services?

1.7.12. Do you have any achievements/successes with present appointing practices?

1.7.13. Do you have any problems with present appointing practices?

2. Define OA Commitments by Analyzing Data.

In the paragraphs below describe population demographics, PCM enrollment and distribution, patient demand, backlog, waiting times, and supply patterns, and staffing. Identify all data sources next to each item (i.e. MAJCOM website, TRICARE Operations Center, CHCS/CHCS II, ICDB, MCFAS, P2R2, M2, etc.).

2.1. Determine Population Demographics.

2.1.1. Enrolled Population. Identify your Active Duty, Prime and Plus beneficiaries for the OA implementation. The objective of this analysis is to define the beneficiary population so demand can be predicted. An enrolled population is definable and their demand for care reasonably predictable.

2.1.2. Non-Enrolled Population. If a facility provides care to non-enrolled patients, defining this population and the extent to which their needs are currently being met by the facility is required. If the facility does not currently meet all the potential demand for care by eligible non-enrolled patients, then some procedure to regulate non-enrollee care must be used so that demand is predictable and manageable. You will need to consider the following groups of non-enrolled beneficiaries: 1) Reserve/Guard; 2) Transient eligibles; 3) Prime Remote; 4) Foreign eligibles; 5) DoD employees (teachers); 6) Accession patients; 7) ROTC encampment; 8) Students; 9) Secretarial Designees; 10) Civilian pay patients (state hired, etc).

You may reflect your population similar to the example table below:

TABLE 1: XXTH MEDICAL GROUP PATIENT POPULATION *			
ACTIVE DUTY PRIME	974	2225 TRICARE PRIME/PLUS	2815 TOTAL ELIGIBLE PATIENT POPULATION
NON-ACTIVE DUTY PRIME	1235		
TRICARE PLUS	16		
TRICARE STANDARD	15	590 OTHER ELIGIBLES	
CIVILIAN ELIGIBLE	240		
OTHER (OCC HEALTH)	335		

2.2. Determine PCM and PCE enrollment and distribution.

This analysis is important to ensure your targeted PCM/PCE(s) provide both daily access and continuity. Each PCE must have the capacity to provide for the daily demand of the enrolled panel. It must be possible to distribute enrollees among providers so that each PCM/PCE's panel size is proportional to that provider's capacity. If there are a substantial number of non-enrollees and other demand, their impact on the capacity of PCMs must be clarified. At a minimum you need to provide:

2.2.1. Enrollees/empanellees per PCM
2.2.2. Enrollees/empanellees per PCE
2.2.3. Estimated volume of other visits (non-enrolled) per month per PCM
2.2.4. Estimated volume of other visits per month per PCE

Table 2: Example of how this information should be displayed:

PCM Provider	# Enrollees (Firm)	# Non-Enrollees Visits (Estimated)
Jones	1,500	25
Smith	1,400	25
Brown	1,600	25
Harper	1500	
Gold PCE	PCE Total of 6000	25 per month average

2.3 Determine Patient Demand for Care.

Conduct a demand analysis. A demand analysis is a vital step to ensure you provide adequate appointments to meet the needs of your patient population. A few suggested methods to follow are listed below:

2.3.1. Civilian Benchmark

Use of civilian benchmark is probably the quickest method to estimate demand. Mark Murray, the father of Open Access, states .75% of an enrolled population will seek care on a given day. To use this method, simply multiply your MTF's enrollment by .0075. That will provide you an estimated number of appointments needed per day. This rate may be lower than your actual utilization rates for your facility, because Dr. Murray is using rates for civilian healthcare institutions were demographics and barriers to care may be different than those in the military. The military benchmark is 1.7% of an enrolled population will seek care on a given day.

2.3.2. MTF Utilization rate

A historical MTF annual utilization rate can be used to make better estimates of primary care utilization and mission requirements for the MTF. You will need to know your MTF's annual utilization rate. The AFMS Population Health Division/AFMSA/SGOZ computes monthly and annual rates for each calendar year for each AFMS MTF. To get these rates you will need to go to the AFMS Knowledge Exchange at URL: https://kx.afms.mil/healthbenefits. Look for the major subheading on the front page entitled, AFMS CY 03 Utilization Rates.

To estimate the number of primary care visits your facility will need to deliver during a 12-month period, multiply your MTF's annual utilization rate by the number of MTF enrollees. For a monthly rate, multiply your MTF's monthly utilization rate by the number of monthly MTF enrollees on the charts. This estimate includes visits for non-enrollees too, as it is based on historical data for all primary care visits delivered by the MTF, but uses the enrolled population as a reference population for ***all*** primary care visits. A more precise description of the estimate would be "annual or monthly primary care visits expected for the potential eligible population". This estimate assumes the MTF has essentially the same number of providers as CY 2003 and has no loss of any CY 2003 primary care services, i.e., MTF had a pediatrician in CY 2003, but was lost to PCS in CY 2004 with no replacement. Divide the annual count by 12 for a monthly count and 18 for a daily count.

As a broad planning factor, the AFMS primary care utilization rate is 3.54 visits per enrollee/per year. For smaller MTFs and/or those in less populated areas, the rate may be greater than 5.5 visits/year. According to the AFMS Population Health Division AFMSA/SGOZ, the annual visits rates range from 2.14 visits/year (Los Angeles) to 5.64 visits/year (Vance). Again, see the charts listed at the URL above for your MTF's monthly and annual rates.

For a more specific view of appointment usage and the appointment mix, you may want to utilize the Access Improvement Module. To access this data you will need to go to URL: http://aim.ha.osd.mil. This tool will assist you in confirming other estimates that you make.

2.3.3. Demand Analysis Process.

Conducting a full-blown demand analysis should provide a more accurate demand estimate; however it will take additional time and effort to complete. The foundation of a demand analysis starts with capturing historical demand. Because historical demand does not necessarily depict all the actual demand, it is necessary to consider the following factors and make necessary adjustments. (This list is not an all inclusive listing of data sources):

2.3.3.1. Telephone system capability (call volume, abandonment rates)
2.3.3.2. Emergency Room/Acute Care Clinic visits
2.3.3.3. Care deferred to network
2.3.3.4. No-show rates
2.3.3.5. Clinical Preventive Service Backlog
2.3.3.6. Un-booked appointment numbers and rates
2.3.3.7. Waitlisted counts and rates

By capturing this potential deflected demand, you can better plan for the actual demand needed to care for your population.

2.3.4 Describe your final demand analysis conclusions.
From the analysis above, report your findings and conclusions.

2.4. Determine Backlog.
Provide a report on your present backlog. By calculating the backlog for your potential PCE(s) or Clinic(s) you can give an indication of the amount of effort required to implement OA . Your total backlog is the sum of all the patients pre-booked into the future. It is obtained by counting all of the pre-booked appointments to obtain the total number. By calculating the backlog for your potential PCE(s) or Clinic(s) you can give an indication of the amount of effort required to implement open access. Conceptually, these pre-booked appointments can be divided into two groups, "good" backlog, and "bad" backlog. Good backlog consists of patients who were offered but declined an appointment for today, and also patients instructed to book a follow up appointment in the future. All other future booking is considered bad backlog, because it represents work that could have been done today. The point at which backlog can be reduced to "good" backlog varies by community. At many clinics, good backlog will be in the range of 20-30 patients per 1000 beneficiaries. If a clinic has a beneficiary population of 5000, good backlog will be in the range of 100 – 150 pre booked patients. If the clinic currently has a backlog of 450, then to implement open access, the clinic/PCE will require a reduction of the backlog by about 300 patients. Determine your good backlog and bad backlog. Give the date based on your "Go Live" date that you plan on having your bad backlog down to OA levels. Do not discuss your backlog reduction plan here.

2.5. Determine Waiting Times.
Identify the waiting times for the potential OA areas. Waiting times and backlog are related measurements. In general, higher backlog results in longer waiting times for appointments. Determining the baseline waiting time will give an indication of current access deficiencies and the value to be obtained by improving access. It also provides the starting point to which improvements can be compared. Waiting times can be calculated in several ways. Two examples are:

2.5.1. Third Available Appointment Method. The classic way of measuring waiting time is to pick an appointment type that is normally delayed into the future, such as the Wellness appointment and to search for the third available appointment. The reason for looking at the third appointment is that there are often cancellations that may open up an appointment or two for today, but this does not accurately reflect the real waiting time, which may be 2 or 3 weeks. By plotting the 3rd available over time, reductions in delays can be monitored.

2.5.2. Average Waiting Time Method. In this approach one monitors when appointments are booked in relation to when they are requested. An average waiting time for appointments can be determined by looking at every booking. An appointment booked today counts as "0", tomorrow as "1", 2 days out as "2", etc. The waiting time for every booked appointment on a given day is summed and divided by the total number of appointments booked

to give an average waiting time for appointments. Clearly the more appointments that are booked today (day "0"), the lower the average waiting time for an appointment. If all appointments were booked for the current day, then the average waiting time would be "0". This data can be extracted from the CHCS Access To Care Summary Report.

2.6. Assess PCE Continuity.

Determine your present PCE continuity and describe your business plan to book patient's primary care needs to meet the continuity of care goal where patients will be booked with their PCM to the greatest extent possible. The patient makes the ultimate decision between access standards and PCM continuity. The main goal is to maintain PCE continuity. The plan can describe use of personnel, appointing procedures, the handling of provider absences, and use of information systems and measures/metrics.

3. Staffing.

Discuss your full range of staffing to support the OA process at your MTF. Base staffing on your number of staff authorized versus assigned (Check your Unit Manning Document (UMD), future MAPPG and staffing models).

3.1. Perform optimization/efficiency analysis to determine proper use of provider and support staff.

Analyze if your MTF has adequate staffing to initiate and sustain OA in the following paragraphs in this section.

3.1.1. Optimization. Discuss your MTF's optimization efforts as they relate to the potential OA areas. Discuss team development, knowledge and their buy-in.

3.1.2. Provider staffing. Discuss how medical providers will ensure that open access imperatives are met, to include number of appointments per provider, summer rotations, coverage for provider absences, and control of leaves/TDYs. Discuss the roles of both PCM and non-PCM providers to include use of Physician Assistants, Nurse Practitioners, residents and providers serving in command and leadership positions. Provide a subjective gauge of this group's "buy-in" to OA.

3.1.3. Support Staffing. Address the use of 4As, 4Ns, resource sharing, contractors, nurse run clinics, nurse triage and use of Care Extender Protocols (CEP) to make operations more efficient. Describe how you will meet the 75 percent available requirement as stated in the policy guidance. Provide a subjective gauge of this group's "buy-in" to OA.

3.1.4 Contingencies.

Describe contingency plans for deployments, staff shortages, information system downtime, readiness exercises, excessive patient demand, etc.

4. Additional Support Requirements.

Discuss the impact of OA on appointing services, medical records, ancillary support services, and other support functions as applicable.

4.1. Assess appointment system's capability to handle the increase in same-day appointing.
Discuss your MTF's plan for supporting the OA appointing process. Discuss call-handling protocols to include: MTF or contractor phone capabilities to handle daily call volumes, nurse triage support (if applicable), unmet demand (unbooked appointment request report) and staff training on how to handle patients.

4.2. Assess your MTF's medical records processing function's capability to handle the increase in same-day appointing.
Discuss the medical records section's ability to support OA. Discuss medical records staffing, location, availability, filing backlog, ambulatory data record completion rates, coding processes, third party collection efforts.

4.3. Assess your MTF's ancillary services capability to handle the increase in same-day appointing.
Discuss laboratory, radiology, and pharmacy's role and ability to adequately support OA in your potential OA areas.

5. Plan for Extended Hours.
In this section you will need to discuss your MTF's procedures if hours will need to be extended to cover increased fluctuations in demand. Describe who makes this decision and necessary coordination to be made for support personnel and facilities.

5.1 MTF targeted area.
Discuss the extended hours plan for your potential OA PCEs/Clinics to include provider and support team staff extension of hours, compensatory time resolution and triggers for extending hours.

5.2 Support and Ancillary Area(s).
Discuss the extended hours plan for supporting and ancillary areas ability to support the potential OA PCEs/Clinics.

6. MTF Goals for Open Access Appointing.
Provide a short explanation of the goals your MTF wants to achieve in the areas of access, backlog control, waiting times, percent of same day work completed, provider/PCE continuity, and provider, staff, and patient satisfaction.
Example responses for Paragraph 6:

- Acute Access To Care Met Standard: 95 percent
- Backlog of 100 appointments on the books at any one time
- Overall PCE average waiting time of .5 days
- 70 percent of same day work completed

7. Discuss Strategies For Implementing OA Appointing.
Discuss plan for working down backlog, matching supply and demand, increasing continuity, increasing supply, decreasing demand, and maximizing office efficiencies.

7.1. Plan for Working Down Backlog.

Discuss how you will work down backlog as identified in paragraph 2.4 above. The plan should discuss how bad backlog is identified and what additional effort is required to control it prior to the "Go Live" date. Discussion should focus on issues such as: provider leave control; the possibility of extending clinic hours; reducing administrative time; reducing or changing meeting times, communications with Wing and base personnel, etc.

7.2. Plan for matching supply and demand.

Discuss plan to right size PCE; how you will manage templates and schedules; and what appointing guidelines will be used.

7.2.1. Panel Size. Discuss issues such as the number, age, acuity, and gender of empanelled beneficiaries and the provider's experience.

7.2.2. Template/Schedule Management. For the potential OA areas, the MTF needs to briefly answer the following:

- What appointment types are going to be used? e.g. OPAC, EST, PROC.
- What method of Good Backlog appointing is going to be used?
- With the appointment types mentioned above, for what services are these appointment types going to be used?
- What detail codes are going to be used? e.g. WEA, CB, GDBL.
- For the detail codes mentioned above, for what purpose are they going to be used?
- What is your plan for controlling templates and schedules? What, Who, When, Why?
- What is going to be the number of slots required per day for each day of the week?
- What is your plan for the creation and opening of schedules and by whom?
- What are the necessary number of days and/or weeks of available appointment slots that need to be open?
- What are the appointment types that will be frozen and why?
- What are the appointment types that will not be frozen?
- How will your potential areas schedule wellness services such as pap smears, physical exams, preventive health assessments, etc?
- How will the MTF schedule procedures?
- What are going to be the rules on splitting and joining appointment slots?
- How will the potential OA PCE(s) or Clinic(s) file and tablel be constructed?
- What is the plan for TRICARE Online OA appointing?
- What is the plan for Nurse - Tech run clinic scheduling?

7.2.3. Appointing Process Guidelines. Discuss the following:

- Use of OA appointing scripts/algorithms for the appointing agents

- Training of "appointment agents" and others who book appointments under OA
- Guidelines to ensure that patients are not directed to call back if appointments are full
- Guidelines for booking patients whose PCMs are on leave or absent
- Guidelines on facility cancellations
- Guidelines on ending the clinic day
- Guidelines on extending the clinic day
- Guidelines on overbooking patients
- Guidelines on "walk-in" patients
- Guidelines on changing appointment types
- Guidelines on patients not wanting to take appointment offered
- Guidelines on booking follow-ups prior to patient leaving the clinic
- Guidelines on provider book only, MTF book only, and provider security keys (to set up appropriate access rights)
- Guidelines on planned down days, restricted days, training days
- Guidelines on "no shows", "late shows," and "left without being seen"
- Guidelines on "unbooked" searches
- Guidelines for telephone consults

7.3. Plan For Increasing PCE Continuity.

Discuss strategies on how MTF will increase PCE continuity.

7.4. Plan for Increasing Supply of Appointments.

Discuss strategies for increasing the supply of appointments. Strategies may include limiting or changing days of meeting times and planned expansion; use of reservists; use of resource sharing providers; use of technicians and CEPs; use of network providers, etc.

7.5. Plan for Decreasing Demand.

Discuss strategies for decreasing demand for appointments. Topics such as the proper booking of follow-ups to prolong the need for a patient's return to the clinic; conditions that can be handled by technicians or nurse run clinics; the handling of prescription refills; use of telephone consults to provide good service without an appointment; providing immunizations; daily monitoring of schedules; self-care; etc.

7.6. Plan for Maximizing Efficiencies.

Discuss strategies such as:

- Office layout and capacity
- Exam room standardization
- Elimination of bottlenecks
- Results of cycle time measurements
- Commitment to starting each morning on time
- Huddles/team meetings/PCE Integrity
- Use of population driven data, e.g. PIMR, HEDIS, ICDB, MHS Portal, M2
- Appointing and records layout (centralized or decentralized)

8. Discuss Measurement and Metrics.
In addition to AFMS required metrics, state how you will measure, track, and trend your OA processes. Measures may include continuity of care, demand for appointments, waiting time, percent of same-day booked appointments, PCM enrollment, backlog, percent same-day open appointments, no-show percentages, etc.

9. PCE's and or Clinics not moving to Open Access Appointing
Discuss the applicable PCEs or clinics in the MTF and analyze what effect OA appointing will have on their operations. Address possible positive and negative effects.

10. Marketing Plan.
Discuss whether or not internal and/or external marketing will be done and how.

11. Discuss any other pertinent issues not covered in the above paragraphs.

12. Coordination with TRICARE Regional Office, Multi-Market Office (if applicable), MAJCOM and Other Agencies (e.g. VA/DoD, etc.).

Date:
Prepared By:
Physician Champion's Signature Block:
MTF Commander's Signature Block:
Listing of Attachments, or Reports